UNITED STATES OF AMERICA
BEFORE THE NATIONAL LABOR RELATIONS BOARD
REGION SIX

FAIRMONT GENERAL HOSPITAL, INC.

Employer

and Case 6-UC-476

RETAIL, WHOLESALE AND DEPARTMENT STORE UNION COUNCIL, LOCAL 550, UNITED FOOD AND COMMERCIAL WORKERS INTERNATIONAL UNION

Union-Petitioner

REGIONAL DIRECTOR'S DECISION AND ORDER

The Employer, Fairmont General Hospital, Inc. operates an acute care community hospital in Fairmont, West Virginia, where it employs about 180 nonprofessional employees represented by Retail, Wholesale and Department Store Union Council, Local 550, United Food and Commercial Workers International Union, the Union-Petitioner (Petitioner).[1] In this proceeding, the Petitioner filed a petition with the National Labor Relations Board under Section 9(b) of the National Labor Relations Act seeking to clarify the existing nonprofessional bargaining unit to include the director of the occupational medicine department and the occupational medicine coordinator. A hearing officer of the Board held a hearing and the parties filed timely briefs with me.

As evidenced at the hearing and in the briefs, the parties disagree on the following issue: whether the existing nonprofessional unit should be clarified to include the occupational medicine director and the occupational medicine coordinator.

[1] The collective bargaining agreement which expired on June 30, 2006, recited that the nonprofessional employees were jointly represented by the Retail, Wholesale and Department Store Union Council and Local 550.

The Employer first contends that the petition must be dismissed because the occupational medicine director and the occupational medicine coordinator are supervisors and/or managerial employees. In the alternative, the Employer contends that the petition must be dismissed because the occupational medicine director and the occupational medicine coordinator historically have been excluded from the Petitioner's bargaining unit, even while the parties have negotiated successive contracts.

The Petitioner, contrary to the Employer, first contends that the positions at issue are not supervisory or managerial. Further, the Petitioner, contrary to the Employer, contends that the duties of the disputed positions have evolved to such a degree that the disputed positions are not successors to the previous positions which were excluded from the bargaining unit. Since the disputed positions are in effect new nonprofessional positions, the Petitioner contends they must be accreted into the existing nonprofessional unit.

I have considered the evidence and the arguments presented by the parties on each of the issues. As discussed below, I have concluded that the occupational medicine director is a supervisory and managerial employee properly excluded from the bargaining unit. Further, I have concluded that the occupational medicine coordinator is not a supervisory or managerial employee, but that the occupational medicine coordinator historically has been excluded from the bargaining unit and therefore cannot be accreted into the unit. Accordingly, I have issued an Order dismissing the petition.

To provide a context for my discussion of the issues, I will first provide an overview of the Employer's operations. Then, I will present in detail the facts and reasoning that supports each of my conclusions on the issues.

I. OVERVIEW OF OPERATIONS

The Employer, a West Virginia corporation, operates an acute care community hospital in Fairmont, West Virginia. The hospital has 252 beds and offers a variety of health care

services to the local area. In addition to the main hospital in Fairmont, the Employer also operates five off-site facilities.[2]

The Employer employs a total of about 700 employees. The RNs, LPNs and certain technical employees are represented by District 1199, West Virginia/Kentucky/Ohio, Service Employees International Union (District 1199), while the nonprofessional employees are represented by the Petitioner. As noted, there are about 180 nonprofessional employees in the Petitioner's bargaining unit.

II. BARGAINING HISTORY

The parties have stipulated that in about 1965, the Petitioner was certified as the collective-bargaining representative of a unit of nonprofessional employees.[3] This recognition has been embodied in successive collective-bargaining agreements, including one effective from May 28, 2004 through June 30, 2006, and one presently in effect.[4] The unit has been described as follows:

> All the part-time and full-time nonprofessional employees in the following Hospital departments: Nutrition Services, Engineering, Laundry, Guest Services, X-Ray, Clinical Laboratory, Medical Records, Central Supply, and Patient Services. There is excepted from the above departments all clerical and administrative employees, other than ward secretaries, and all clerical employees (except in the Medical Records department); all department heads and their assistants; student employees; and supervisors.
>
> The term, "nonprofessional employees," is intended to exclude those whose occupations require a course of study or an extensive technical training course or apprenticeship, such as laboratory technicians, registered or licensed practical nurses, or dietitians.[5]

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[2] Except as discussed herein, the Petitioner does not represent any employees at the off-site locations.

[3] The Regional Office records do not reflect such a certification by this Region. It is noted that the Health Care Amendments, Public Law 93-360, 93 Cong., 2d Sess., S.3203, granting the Board jurisdiction over health care institutions, such as the Employer herein, were not enacted until 1974.

[4] The record does not reflect the effective dates of the current contract.

[5] This unit description is from the collective bargaining agreement which expired on June 30, 2006. However, the record does not reflect that there has been any change to this language in the current contract.

III. OCCUPATIONAL MEDICINE DEPARTMENT

The Employer has an occupational medicine department, which offers such services as independent medical exams, injury management, physical agility testing, drug testing, audio tests, vision screening, pulmonary function testing and electrocardiograms. The director of the occupational medicine department is Pamela Payne, who, in turn, reports to the Assistant Vice President of Business and Operations Development, Kimberly Cheuvront. Reporting directly to Payne are the occupational medicine coordinator and a full-time occupational medicine assistant.[6] There is also a full-time occupational medicine physician, Dr. Steinman, who provides services as an independent medical examiner for injured employees. There are two nurse practitioners, who are responsible for performing pre-employment physicals.[7]

The occupational medicine department is one of the hospital's out-patient programs. Other out-patient programs include physical therapy, pulmonary rehab and cardiac rehab. The occupational medicine department is located in an off-site building separate from the hospital.

The occupational medicine facility is open from 8:00 a.m. to 4:30 p.m., Monday through Friday. Presently, on average, about 30 patients are seen at the facility each day. In addition, the occupational medicine department provides off-site services at employer facilities with variable hours. Further, the department is considered open 24 hours a day, 7 days a week, and someone is always on-call.[8]

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[6] There had also been a part-time occupational medicine assistant, but that employee was discharged in January 2006, and has not been replaced. The circumstances of the discharge are discussed more fully in the text below.

[7] A nurse practitioner position was added to the staff in about January 2005; it appears that there are currently two nurse practitioners working at the facility, one working full-time and one working part-time.

[8] In an after-hours situation, the patient reports to the hospital, and the occupational medicine coordinator is paged. The coordinator usually performs the testing herself, but she may have the assistant go instead.

A. History of the Occupational Medicine Department

The occupational medicine department has evolved over the years from its inception in about 1991. In about 1991, the hospital began offering services that have come to be known as occupational medicine. These services were performed in the hospital's clinical lab by lab technologists, who were represented by District 1199.

In about 1998, the hospital assigned an LPN to perform the occupational medicine clinical functions, instead of the lab technologists. The LPN, like the lab technologists, was represented by District 1199. Around that time, a lab secretary, who was part of the Petitioner's bargaining unit, was assigned to handle the clerical functions related to occupational medicine. In addition to performing these clerical functions in the hospital, at times the lab secretary assisted when drug testing was performed at an employer's facility.[9]

Subsequently, in about 1999, the hospital retained Brian Pulice to direct the occupational medicine department.[10] Pulice was employed by a management services company, which was a subsidiary of the hospital. His primary responsibilities were sales and marketing, and he spent most of his time on the road.

Several years later,[11] the occupational medicine department had outgrown the available space in the hospital lab, and moved off-site to a space adjacent to the physical medicine office. At that time, both the LPN (Cindy Ralphsnyder) and the lab secretary (Janice Diven) who had been assigned to the program relocated to the new space. After relocating, the LPN left the occupational medicine department to accept another position with the hospital.

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[9] On those occasions, the lab secretary would handle paperwork to establish the chain of custody, take the temperature of urine specimens, and seal the specimens in bags.

[10] Pulice's title was Occupational Medicine Coordinator.

[11] While Cheuvront testified that the relocation occurred in 2000, a memo from Pulice announcing the relocation establishes that it occurred in April 2002.

The hospital did not replace the LPN in the occupational medicine department, but instead created a new position of occupational medicine services coordinator responsible for performing clinical functions. The job description for this position states that the position is "responsible for all patient flow support activity" in the program.

In August 2002, lab secretary Diven was awarded the newly created position.[12] The Employer considered the newly created position to be a non-bargaining unit position. According to the Employer, both the Petitioner and District 1199 were notified of the creation of the position of occupational medicine services coordinator, and neither union asserted that the position was within its bargaining unit.

About the same time that the hospital created the new occupational medicine services coordinator position and awarded it to Diven, the hospital awarded the lab secretary position formerly held by Diven to Brenda Schell, who had formerly been a lab secretary in the hospital lab. While the occupational medicine services coordinator position was considered non-bargaining unit, the lab secretary position occupied by Schell continued to be part of the Petitioner's bargaining unit covered by the contract. As a lab secretary in the occupational medicine department, Schell also performed some minor clinical functions.

In about October 2004, the hospital replaced Pulice with an in-house program director, Pamela Payne. At that point, certain clerical functions associated with setting up new client accounts that had been performed by Schell were taken over by Payne.

In about June 2005, Payne approached hospital management to discuss the growth in demand for clinical services in the occupational medicine department, along with a decreased need for clerical services. Payne initially proposed hiring another occupational medicine services coordinator, but Payne also wanted Diven to be able to assume some oversight

[12] Although the newly created position had a title similar to Pulice's title, the functions were quite different. While Pulice focused on sales and marketing, Diven was performing clinical functions in the program.

responsibilities. It was decided to create three new clinical positions to staff the program: an occupational medicine coordinator,[13] an occupational medicine assistant I (a part-time position) and an occupational medicine assistant II (a full-time position). All three positions were considered by the Employer to be non-bargaining unit positions. At the same time, it was decided to eliminate the lab secretary position.[14]

Diven was awarded the occupational medicine coordinator position, and Schell was awarded the full-time assistant position. The part-time assistant position was also filled, but that employee was discharged in about January 2006, and the position has not been filled.

B. The Disputed Positions

In the present proceeding, the Petitioner seeks the clarification of the nonprofessional bargaining unit to include two positions: the occupational medicine director position currently held by Payne, and the occupational medicine coordinator position currently held by Diven. Details of these positions are set forth below.

1. The Occupational Medicine Director

Payne became the director of the occupational medicine department in October 2004. Payne holds two bachelor's degrees, and a masters in safety management and a masters in health administration, as well as a doctorate in health administration. As department director, Payne sets the standards and guidelines for the department and is in the process of developing a policy and procedure manual for services provided by the department. She is responsible for preparing and monitoring the department's budget and makes proposals for capital expenditures. She oversees the workload of the department, she directs the staff of the department, and she prepares performance appraisals and competency assessments on department staff. She oversees the quality assurance of the department and ensures that all

[13] In contrast to the "occupational medicine services coordinator" position.

[14] The lab secretary position was eliminated effective July 15, 2005.

staff have current licenses and certifications.[15] Payne attends monthly meetings of the hospital department heads and serves as a liaison between the hospital administration and the department staff. She is knowledgeable about the laws and regulations impacting occupational medicine.

Payne is responsible for marketing the services provided by the department and she maintains a working relationship with local industries served by the department. Payne maintains contact with local employers, provides them with information about the services offered and the fees charged, and with the staff certifications. She performs the related clerical tasks, such as faxing information to employers, and she also performs the clerical work necessary to set up accounts for employers.

Payne is also certified as an occupational hearing conservationist, a drug screen collector, a hair screen collector, and a saliva collector, but she does not perform tests on patients seen in the department. Payne explained that she obtained the certifications in order to better familiarize herself with the work of the department.

At present, Payne's office is in the facility that houses the occupational medicine department, and she is present at the facility about 70 to 75 percent of the time.[16]

Payne testified that she has the authority to make job offers without consulting with Cheuvront or with the Human Resources Department. Payne, in conjunction with Cheuvront, hired the occupational medicine physician and the nurse practitioner.[17] In addition, in about January 2006, Payne, in conjunction with the Human Resources Department, discharged the part-time occupational medicine assistant. This employee had hurt her shoulder and was off

[15] The employees are responsible for keeping their licenses and certifications current.

[16] Previously, Payne's office was located in the hospital and she was present at the facility only 50 percent of the time.

[17] The physician began on an as-needed basis in June 2005, and became full-time in September 2005. The nurse practitioner position was added to the staff in about the beginning of 2005.

work receiving short-term disability. While the employee was off work, it was discovered that she was working in another doctor's office. Payne was advised of the situation, apparently by Diven, and confirmed the circumstances reported to her. Payne then discussed the situation with the Human Resources Department, and they jointly decided to discharge the employee.

Payne is a salaried exempt employee paid on the management pay scale.

2. <u>The Occupational Medicine Coordinator</u>

Diven testified that she was first a lab secretary and then became the occupational medicine assistant/lab secretary. She testified that she became the occupational medicine coordinator in 2002. [18] She testified that both the lab secretary and the occupational medicine assistant/lab secretary jobs were in the bargaining unit. Diven testified that when she became the occupational medicine coordinator in 2002, she stopped paying union dues.

Diven identified two principal differences in her duties and responsibilities between the occupational medicine assistant/lab secretary job and the occupational medicine coordinator job. First, Diven explained that as occupational medicine coordinator, she obtained certifications that permitted her to perform additional testing and to draw blood, and she then performed those additional duties. Second, Diven testified that as occupational medicine coordinator, she assumed responsibilities related to off-site programming, which are described more fully below.

As the occupational medicine coordinator, Diven calibrates the equipment every morning before the facility opens.[19] Diven also ensures that new personnel are familiar with the particular equipment utilized at the facility, and trains them on the use of the equipment if

[18] According to the Employer's records, the position Diven assumed in 2002 was the position of occupational medicine services coordinator, and in 2005, Diven became occupational medicine coordinator, the position she holds today. Apparently, Diven herself does not differentiate between these two positions.

[19] The occupational medicine assistant has also been trained to calibrate the machines, and calibrates those machines that require calibration between patients.

necessary. During the day, she performs various tests on patients. Diven also enters information into the computer for billing purposes. As explained more fully below, Diven also performs work related to off-site programming throughout the day.

Diven has adjusted patient scheduling to maintain the flow of patients in the facility. When a nurse practitioner complained that scheduling patients every half hour was causing patients to back-up, Diven met with the staff, and it was decided to change the scheduling to every hour.[20] If the nurse practitioner calls off work, Diven will first attempt to cancel or reschedule the nurse practitioner's appointments. If that is not possible, Diven will notify the contract doctor and he will cover those appointments. If this occurs, the occupational medicine department is billed for the contract doctor's time.

In addition to contacting the contract doctor, Diven has adjusted staffing in other ways to accommodate the volume of work. Recently, the occupational medicine assistant was off work for 10 to 12 days due to jaw surgery. The assistant notified Diven of the surgery, and Diven notified Payne the next day. Thereafter, the HR department granted the assistant an excused leave. The assistant called Diven on a daily basis to report on her status and advise Diven when she would be able to report to work.

In addition, on one day during the week preceding the hearing, an employee was not able to report to work when scheduled, and was going to come in late. Diven told the employee that patients had canceled, and the employee should stay home. Other times, when patients have canceled appointments, and Diven has told the nurse practitioner to go home instead of sitting there, or has told the nurse practitioner to report to work late. If an employee wants to take a day off, the employee can speak to either Payne or Diven. Diven is familiar with the

[20] The record does not reflect whether Payne participated in this decision.

staffing needs and will tell the employee whether the employee can take off. If the situation presented is complicated, Diven will check with Payne first.[21]

In addition to her duties at the facility, Diven explained that she is responsible for coordinating the off-site services provided by the occupational medicine department, such as health fairs, drug testing, and flu clinics held at various employers' facilities. The department conducts about 20 health fairs a year, and has flu clinics about 3 days a week from September through December or January. Diven communicates with employers regarding the scheduling of these programs, and arranges the dates and times. She also provides the employers with the pre-determined fees charged for the various services. If the employer has a large number of participants, Diven may adjust the fee "a little bit." For example, if the employer arranges for 100 employees to be drug tested, Diven may reduce the cost by $5. In addition, she may adjust the fees if the employer is providing its own supplies.

Diven determines the appropriate staffing levels for the off-site programs, and notifies the occupational medicine department personnel of the hours they are to work.[22] These programs may be staffed by Diven alone; by Diven and the occupational medicine assistant and/or nurse practitioner; or by occupational medicine department staff supplemented by staff from other hospital departments and students.[23] As a result of the staffing, overtime costs may be incurred, which can be $5000 for a large event. If personnel from outside the occupational medicine department are required, Diven recruits them. Diven orders supplies for these programs, which can cost $5000 for a large event.

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[21] Vacation scheduling is decided by the staff, apparently on an informal basis, and Payne is informed of what they have decided.

[22] If, during the event, Diven discovers that additional personnel are needed, she can contact them directly, without prior approval from Payne.

[23] The staffing for a health fair may include a physician.

Diven testified that on one occasion she was required to intercede in a dispute among personnel working at a health fair. Diven explained that there were two hospital employees working at the health fair who were upset that there were students performing tests. These employees "caused a huge scene" and the superintendent of the company where the fair was being held was contacted. Diven testified that she told the complaining employees, "Either knock it off, or I will send you home." The employees calmed down and no one was sent home.

When Payne is absent from the facility, Diven is considered in charge; however, the Employer has not identified any actions that Diven has taken in Payne's absence which would denote supervisory authority.

Diven is on-call during the evenings and weekends. She generally responds to the calls herself; but the occupational medicine assistant is Diven's designated back-up, and Diven may refer calls to the assistant.

Before the department hired a part-time occupational medicine assistant in July 2005, Payne interviewed about 12 candidates. Diven testified that she sat in on the interviews Payne conducted. Diven testified that Payne said, "You know a lot about the clinical part of it. You seen [sic] her qualifications. What would your suggestion be of who the occupational medicine department needs to hire?" Diven made a recommendation, and that individual was in fact hired.

The occupational medicine coordinator's job does not require a college degree. It is paid hourly and the coordinator is eligible to receive overtime pay or take compensatory time. The job description for the occupational medicine coordinator position does not disclose any authority to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances. The only reference which resembles any of these factors is the provision that "[i]n absence of director coordinates day-to-day operations. Maintains contact with director when applicable."

IV. NONPROFESSIONAL UNIT

As noted, the Petitioner represents the nonprofessional employees working in the hospital. Many of these nonprofessional employees, such as the certified nurses aides, noncertified OR techs and clerk-secretaries, perform duties similar to the clinical and clerical duties performed in the occupational medicine department.

By way of specific example, included within the Petitioner's nonprofessional unit are medical assistants working in the emergency room. These medical assistants perform secretarial functions in the emergency room, draw blood, cast splints, clean and dress wounds, transport patients, prepare patients, assist with minor surgical procedures such as stitches, perform urinary catheterizations and perform vision tests.

Just as the employees in the occupational medicine department must be certified to perform various clinical tests, the medical assistant position in the emergency room requires completion of a 10 month, full-time, medical assistant training program. In addition, other positions within the Petitioner's bargaining unit have also been modified to require increased certification. For example, the parties recently agreed to increase wage rates for the OR techs and certain building maintenance employees because their jobs had become more complex and required more certifications.

Further, just as the employees in the occupational medicine department may work off-site and on an on-call basis, also within the Petitioner's bargaining unit are employees who work off-site and work on an on-call basis. Thus, within the nonprofessional bargaining unit are five transcriptionists who work out of their homes and OR techs who may be assigned to an on-call status.

V. PRIOR UNIT CLARIFICATION

The present petition is the second time the Petitioner has sought the clarification of the nonprofessional unit to include occupational medicine employees. Previously, in Case 6-UC-472, the Petitioner requested the inclusion of the two occupational medicine assistants in the

unit. Following a hearing held on October 3, 2005, by Decision, Order and Clarification of Bargaining Unit issued on December 21, 2005, the unit was clarified to include the two assistants. The Employer's Request for Review of that determination was denied by the Board on June 7, 2006.[24]

VI. ANALYSIS

A. Positions of the Parties

Arguing for inclusion of the director of the occupational medicine department, the Petitioner asserts that, under Payne, the director position has evolved into a clerical position. Further, the Petitioner argues that the occupational medicine coordinator position is so similar to the occupational medicine assistant position, which was recently determined to be a unit position, that the coordinator must also be included in the bargaining unit.

In opposition to the Petitioner's arguments in favor of inclusion of the two disputed positions, the Employer first asserts that a decision in this matter should be held in abeyance until the Board decides a trilogy of pending cases which raise the issue of supervisory status in light of the Supreme Court's decision in NLRB v. Kentucky River Community Care, Inc., 532 U.S. 706 (2001). In the alternative, the Employer asserts that the director of the occupational medicine department and the occupational medicine coordinator are supervisors under Section 2(11) of the Act and/or managerial employees, properly excluded from the bargaining unit. Finally, the Employer asserts that if the director and coordinator are not excluded based upon supervisory or managerial status, nevertheless these positions are not appropriately accreted into the unit based on their historic exclusion from the unit.

[24] The transcript, exhibits, Regional Director's Decision, Order and Clarification of Bargaining Unit, and Board Order denying the Employer's Request for Review in the prior proceeding were made a part of the record in this matter.

B. Legal Standards

1. Supervisory Status

As noted, the Employer, contrary to the Petitioner, asserts that the director of the occupational medicine department and the occupational medicine coordinator should not be accreted into the existing unit because they are statutory supervisors.

Before examining the specific duties and authorities of the director and the coordinator, I will review the requirements for establishing supervisory status. Section 2(11) of the Act defines the term supervisor as:

> [A]ny individual having authority, in the interest of the employer, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances, or effectively to recommend such action, if in connection with the foregoing the exercise of such authority is not of a merely routine or clerical nature, but requires the use of independent judgment.

To meet the definition of supervisor in Section 2(11) of the Act, a person needs to possess only one of the 12 specific criteria listed, or the authority to effectively recommend such action. Ohio Power Co. v. NLRB, 176 F.2d 385 (6th Cir. 1949), cert. denied 338 U.S. 899 (1949). The exercise of that authority, however, must involve the use of independent judgment. Harborside Healthcare, Inc., 330 NLRB 1334 (2000).

The burden of proving supervisory status lies with the party asserting that such status exists. NLRB v. Kentucky River Community Care, Inc., supra, at 711-712; Michigan Masonic Home, 332 NLRB 1409 (2000). The Board has frequently warned against construing supervisory status too broadly because an employee deemed to be a supervisor loses the protection of the Act. See, e.g., Vencor Hospital – Los Angeles, 328 NLRB 1136, 1138 (1999); Bozeman Deaconess Hospital, 322 NLRB 1107, 1114 (1997). Lack of evidence is construed against the party asserting supervisory status. Michigan Masonic Home, supra, at 1409. Mere inferences or conclusionary statements without detailed, specific evidence of independent

judgment are insufficient to establish supervisory authority. Sears, Roebuck & Co., 304 NLRB 193 (1991).

Possession of authority consistent with any of the indicia of Section 2(11) is sufficient to establish supervisory status, even if this authority has not yet been exercised. See, e.g., Fred Meyer Alaska, 334 NLRB 646, 649, fn. 8 (2001); Pepsi-Cola Co., 327 NLRB 1062, 1064 (1999). The absence of evidence that such authority has been exercised may, however, be probative of whether such authority exists. See Michigan Masonic Home, supra, at 1410; Chevron U.S.A., 309 NLRB 59, 61 (1992). The Board and the Courts have recognized that an employee does not become a supervisor merely because he has greater skills and job responsibilities than fellow employees or because he gives some instructions or minor orders. Byers Engineering Corp., 324 NLRB 740 (1997); Chicago Metallic Corp., 273 NLRB 1677 (1985).

2. Managerial Employees

In addition to asserting that the director of the occupational medicine department and the occupational medicine coordinator should not be accreted into the existing unit because they are statutory supervisors, the Employer, contrary to the Petitioner, asserts that the director and the coordinator should not be accreted into the existing unit because they are managerial employees. Thus, I will review the requirements for establishing managerial status.

"Managerial employees" are defined as those employees who formulate and effectuate management policies by expressing and making operative the decisions of their employer and those who have discretion in the performance of their jobs independent of their employer's established policies. Tops Club, Inc., 238 NLRB 928 fn. 2 (1978), quoting Bell Aerospace, 219 NLRB 384 (1975), on remand from the Supreme Court's decision at 416 U.S. 267 (1974). The decisions must be made in the interest of the employer. Allstate Insurance Co., 332 NLRB 759 (2000).

In NLRB v. Yeshiva University, 444 U.S. 672, 682-683 (1980), the Supreme Court described managerial employees as follows:

> Managerial employees are defined as those who "formulate and effectuate management policies by expressing and making operative the decisions of their employer." These employees are "much higher in the managerial structure" than those explicitly mentioned by Congress which "regarded [them] as so clearly outside the Act that no specific exclusionary provision was thought necessary." Managerial employees must exercise discretion within, or even independently of, established employer policy and must be aligned with management. Although the Board has established no firm criteria for determining when an employee is so aligned, normally an employee may be excluded as managerial only if he represents management interests by taking or recommending discretionary actions that effectively control or implement employer policy. (Case cites omitted.)

C. Application of Standards to Facts

Although the Employer has asserted that disposition of this matter should be held in abeyance pending the Board's decision in a series of cases raising the issue of supervisory status under NLRB v. Kentucky River Community Care, Inc., supra, it is noted that the specific supervisory issues raised in the instant case are the subject of well-settled Board law. Accordingly, I have determined that this matter is ripe for disposition.

1. Director

In support of its contention that the director's position should be accreted into the bargaining unit, the Petitioner argues that Payne performs clerical work when dealing with local employers and setting up new accounts, that Payne holds certifications to perform some of the testing, and that the Employer did not propose the exclusion of the director's position from the bargaining unit during negotiations for the most recent collective-bargaining agreement even though the instant petition was then pending.

Notwithstanding the Petitioner's arguments, the record affirmatively establishes that the director is a supervisor within the meaning of Section 2(11) of the Act. The director has the authority to hire and fire employees and has exercised this authority. Payne testified that she and Cheuvront hired the occupational medicine physician and the nurse practitioners; further, Payne, along with the HR department, made the decision to terminate an occupational medicine assistant. In addition, Payne oversees the workload of the department, directs the staff of the

department, and prepares performance appraisals and competency assessments on department staff.

The record also affirmatively establishes that the director is a managerial employee. She sets the standards and guidelines for the department and is in the process of developing a policy and procedure manual for services provided by the department. She is responsible for preparing and monitoring the department's budget and makes proposals for capital expenditures.

The fact that Payne performs clerical tasks related to her position and possesses certifications to perform testing does not in any way negate her clear supervisory and managerial functions. Accordingly, I find that the position of the director of the occupational medicine department is excluded from the nonprofessional bargaining unit represented by the Petitioner.

2. Coordinator - Supervisory Status

At the outset, I note that during the prior hearing on the issue of the inclusion of the occupational medicine assistants in the nonprofessional unit, Assistant Vice President of Business and Operations Development Cheuvront testified that the coordinator position was not management or supervisory; further, the Employer's Vice President of Human Resources and Legal Services described the coordinator position as performing “quasi-supervisory duties." Further, the record evidence adduced in the most recent hearing establishes that the occupational medicine coordinator remains in the same position that she held at the time of the prior hearing, with the same job description, and according to her testimony, performing the same duties. The record does not disclose that she has been granted any additional supervisory or managerial authority since that time. Nevertheless, the Employer now asserts that the coordinator is a supervisor and/or managerial employee.

With regard to whether the occupational medicine coordinator possesses any of the 12 indicia of supervisory status listed in Section 2(11) of the Act, it is noted that the Employer does

not contend, nor is there any record evidence, to establish that this individual transfers, suspends, lays off, recalls, promotes, rewards or adjusts grievances. In its brief, the Employer asserts that the occupational medicine coordinator is a supervisor based on her authority to assign and responsibly direct employees and to effectively recommend the hiring, firing and discipline of employees. Accordingly, I will address only the Employer's arguments that the coordinator is a supervisory employee because she recommends hiring, firing and discipline, and she assigns and responsibly directs employees.

Initially, it is noted that the record is almost devoid of any documentary evidence that the occupational medicine coordinator has been granted, or has exercised, supervisory authority. As noted, the job description for the occupational medicine coordinator position does not disclose any authority to "hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibly to direct them, or to adjust their grievances." The only reference which resembles any of these factors is the provision that "[i]n absence of director coordinates day-to-day operations. Maintains contact with director when applicable."

Likewise, the job description for the director contains no reference to the coordinator providing assistance to the director when the director is performing her duties. In this regard, the Employer, in its post-hearing brief at pages 4-5, states "The occupational medicine director, with the assistance of the occupational medicine coordinator, oversees employee payroll, formulation of policies, hiring, orientation, competency assessment, employee performance appraisals and the disciplinary process. (476 Employer Ex. 1)" Contrary to the Employer's statement, the cited reference to the director's job description contains no reference to the coordinator assisting the director in any functions.

The Employer contends that the coordinator's scheduling of staff for off-site programs such as health fairs, drug testing and flu clinics, which may result in overtime being incurred, and her adjusting staffing in the facility based on the number of patients requires her exclusion

from the unit. Contrary to the Employer's arguments in this regard, the record shows that one of the coordinator's principal responsibilities is to coordinate the off-site programs, as well as to coordinate the flow of patients through the facility. The hours of the off-site programs are set in conjunction with the employer where the programming is being conducted. Once the nature of the programming and its hours are set, Diven schedules personnel to staff the programming. The personnel may be a physician, a nurse practitioner, the occupational medicine assistant, staff from other hospital departments who have been recruited to participate, and students, or Diven herself.[25]

With respect to coordinating the flow of patients at the facility, when there were patient cancellations, Diven has told the nurse practitioner that she could leave, or come in late. Further, Diven has told the assistant that the volume of work was light and that the assistant did not have to report to work. Similarly, Diven has handled uncomplicated leave requests.

These situations are routine, ministerial and driven by events. As to the facility staffing, common sense dictates that if there are patient cancellations, the nurse practitioner or occupational medicine assistant do not need to report to, or remain at, work. In this case, Diven simply relays information regarding patient cancellations to the nurse practitioner and to the occupational medicine assistant. Certainly, the decision to send an employee home based on the observation that there is no other work to be done does not involve the exercise of independent judgment. Millard Refrigerated Services, 326 NLRB 1437, 1438 (1998)

Further, as to off-site programming, the nature of the programming, the number of expected participants and the hours will determine the number of personnel required to staff the program and the hours they are required to be there. Unquestionably, someone who has been coordinating these programs for several years, as Diven has, is familiar with the staffing

[25] The Employer does not assert that the coordinator supervises the physician or other departmental staff by virtue of her scheduling the off-site services.

requirements. The Employer has failed to establish that Diven has exercised independent judgment in any of these situations.

Given that occupational medicine is an out-patient program, the patients seen through the occupational medicine department bear very little similarity to patients receiving treatment in an acute care hospital or in a skilled nursing facility. Thus, it is unlikely that Diven would be required to assess patient acuity in making staffing determinations, particularly those involving health fairs, drug testing or flu clinics. Further, since the testing and flu injections provided by the occupational medicine department require that personnel have certifications in specific areas, it is also unlikely that Diven is required to make assessments between available staff which involve the exercise of independent judgment; stated otherwise, possession of the required certification is going to determine whether someone is scheduled to perform a certain test or give a certain injection.

When coordinating the off-site programming or the flow of patients through the facility, Diven is more akin to a skilled leadperson, than a supervisor. In this regard, Diven uses her experience and skills, but does not exercise independent judgment as that term has been defined by the Board and the Courts. See Pacific Beach Corp., 344 NLRB No. 140 (2005); Armstrong Machine Co., 343 NLRB No. 122 (2004); Lincoln Park Nursing Home, 318 NLRB 1160, 1162-1163 (1995).

When Payne is absent from the facility, Diven is considered in charge; however, the Employer has not identified any actions that Diven has taken in Payne's absence which would denote supervisory authority.

As to hiring, the Employer, at pages 8-9 of its post-hearing brief, states, "With respect to the scope of her supervisory duties, the occupational medicine coordinator has the authority to hire or effectively recommend the hiring of personnel for the occupation[al] medicine department, including occupational medicine assistants and nurse practitioners. (Tr. 81)" The cited testimony references only the instance of Diven's participation in the interviews of

candidates for the part-time occupational medicine assistant position in July of 2005; there is no reference to any involvement of Diven in the hiring of the nurse practitioners or the physician.

With respect to the hiring of the assistant, Diven testified that Payne interviewed about 12 candidates. Diven sat in on the interviews which Payne conducted, and made a hiring recommendation, and that candidate was in fact hired.[26] Although nurse practitioners and a physician have been hired by Payne, there is no evidence that Diven had any involvement in their hiring.

It is evident that Diven was asked to participate in the interview of the assistant because of Diven's expertise in the clinical functions of the occupational medicine department. Given that the reason for her participation was because of her clinical expertise, it is far from clear that Diven's participation in the hiring of the assistant is indicia of true supervisory status. At the very least, the Employer has not carried its burden of proving that the coordinator has the authority to effectively recommend hiring. See The Door, 297 NLRB 601, 601-602 (1990) (recommendation was limited to whether a candidate had the technical ability to perform the work), cited with approval in J.C. Penney Corporation, Inc. 347 NLRB No. 11 (2006).

As to firing, the Employer, at page 5 of its post-hearing brief, also states that "Based on the information and recommendations obtained from the occupational medicine coordinator, the occupational medicine director decided to terminate the occupational medicine assistant. (Tr. 56, 114)" Similarly, the Employer, at page 9, states "Ultimately, at the conclusion of the investigation, the occupational medicine coordinator provided a recommendation to the occupational medicine director that the occupational medicine assistant be terminated, which the occupational medicine director accepted. (Tr. 114)"[27] Again, contrary to the Employer's statement, the record is devoid of any reference to Diven making a recommendation that the

[26] Apparently, this is the individual that was subsequently fired in January 2006, and has not been replaced.

[27] See also pages 20-21 of the Employer's post-hearing brief.

assistant be terminated. The director's testimony was that she made the decision in conjunction with the HR department. The testimony of Diven was that "the director made that decision." Further, the record testimony was that Diven was part of the investigation of the circumstances, and that she had "input" in the decision.

Nowhere does the record state that the director solicited Diven's recommendation, or the Diven made a recommendation, or that the recommendation was given any consideration by the director. To the contrary, a fair reading of the transcript suggests that Diven's participation was limited to relaying factual information to the director, which the director then confirmed, and then the director made the decision to terminate in conjunction with the HR department. Well-established Board precedent holds that such reportorial authority does not establish supervisory status. See Millard Refrigerated Services, supra, at 1438.

The Employer argues that the coordinator has disciplinary authority, citing an instance when two hospital employees working at a health fair were upset that there were students performing tests and "created a scene." Diven told the employees, "Either knock it off, or I will send you home." It is first noted that this instance involved employees from other hospital departments who had been recruited to work at the health fair;[28] the Employer cites no evidence that Diven has exercised or threatened to exercise any disciplinary authority over the occupational medicine staff. It is also noted that the complaining employees calmed down and no one was sent home or otherwise disciplined. In fact, there was no indication that the incident was memorialized in any way.

Based on the above and the record as a whole, I find that the Employer has not carried its burden of proving that the occupational medicine coordinator is a supervisor under the Act.

[28] While the exercise of supervisory authority over non-bargaining unit employees may so align an individual with management as to warrant exclusion as a supervisor, an examination of the relevant factors does not present such a situation here. Detroit College of Business, 296 NLRB 318, 321 (1989).

3. Coordinator – Managerial Status

The Employer argues that occupational medicine coordinator is a managerial employee because she quotes fees for services offered, offers volume discounts, orders supplies for off-site programming, and may incur overtime in arranging for staffing of off-site programming. As further evidence of managerial status, the Employer relies on Diven having called staff meetings, and having extended the time between patients at the suggestion of the nurse practitioner.

Contrary to the Employer's characterization of these functions, considered individually or in total, they do not constitute the exercise of managerial prerogatives so as to make the coordinator a managerial employee as that term has been defined by the Board and the Courts. Rather, the duties Diven performs in connection with the off-site programming are basically administrative, not discretionary: Diven quotes pre-determined fees for services, she orders supplies, and she schedules personnel based on the hours of the programming. In these circumstances, Diven's authority to grant a discount for volume does not rise to the level of a managerial function.

Further, since the staff of the occupational medicine department consists of Diven, two nurse practitioners and an occupational medicine assistant, calling a staff meeting in these circumstances appears to be fairly insignificant. Finally, as mentioned above, one of Diven's responsibilities is to coordinate the flow of patients through the facility: determining the appropriate intervals at which to schedule patients is part of the core duty. This again is not a true management prerogative.

Based on the above and the record as a whole, I find that the record does not establish that the occupational medicine coordinator is a managerial employee.

D. Nonprofessional Status of Coordinator

Neither party asserts that the occupational medicine coordinator is a professional or technical position. In this regard, the record evidence recited above clearly indicates that the

occupational medicine coordinator is a nonprofessional employee, with training, duties and responsibilities similar to other nonprofessional employees in the bargaining unit represented by the Petitioner.

As set forth above, the Petitioner has represented the nonprofessional employees for about forty years, and the parties have had successive collective-bargaining agreements. The term nonprofessional has been defined by the parties as follows:

> The term, "nonprofessional employees," is intended to exclude those whose occupations require a course of study or an extensive technical training course or apprenticeship, such as laboratory technicians, registered or licensed practical nurses, or dietitians.

The record establishes that the occupational medicine coordinator is a nonprofessional employee as the parties have defined that term in their contract. The certifications which are preferred for the position do not require an extensive technical training course or apprenticeship or a similar course of study which would cause the position to be excluded from the nonprofessional classification as defined by the parties. In fact, the certifications which are preferred for the occupational medicine coordinator position are similar to, but require less intensive training than the training required for the medical assistants in the emergency room, a position covered under the Petitioner's contract.

The clinical functions currently performed by the occupational medicine coordinator are similar to the functions previously performed by the lab secretary in the occupational medicine department, as well as those currently performed by the occupational medicine assistant. Further, some of the clerical functions performed by the occupational medicine coordinator are also similar to the clerical functions previously performed by the lab secretary in the occupational medicine department, as well as those currently performed by the occupational medicine assistant.

Not only are the functions of the occupational medicine coordinator similar to the functions performed by the former lab secretary in the occupational medicine department and

the current occupational medicine assistant, but also the functions of the occupational medicine coordinator are similar to the functions performed by other nonprofessional employees in the Petitioner's bargaining unit, particularly the certified nurses aides and the medical assistants in the emergency room. In addition, the clerical functions performed by the occupational medicine coordinator are similar to the order entry functions performed by the lab secretaries in the clinical lab.[29]

Based on the above and the record as a whole, I find that the occupational medicine coordinator is a nonprofessional employee.

E. Historic Exclusion

The Employer asserts that if the occupational medicine coordinator is not found to be a supervisor or managerial employee, nevertheless the coordinator position may not be accreted into the existing unit because this classification has historically been excluded from the bargaining unit.

The Board described the purpose of unit clarification proceedings in Union Electric Co., 217 NLRB 666, 667 (1975):

> Unit clarification, as the term itself implies, is appropriate for resolving ambiguities concerning the unit placement of individuals who, for example, come within a newly established classification of disputed unit placement or, within an existing classification which has undergone recent, substantial changes in the duties and responsibilities of the employees in it so as to create a real doubt as to whether the individuals in such classification continue to fall within the category—excluded or included—that they occupied in the past. Clarification is not appropriate, however, for upsetting an agreement of a union and employer or an established practice of such parties concerning the unit placement of various individuals, even if the agreement was entered into by one of the parties for what it claims to be mistaken reasons or the practice has become established by acquiescence and not express consent.

[29] While there are some similarities between the former lab secretary position and the current occupational medicine coordinator position, I do not find that the coordinator is a successor to the lab secretary position. Rather, the record establishes that a major part of the coordinator's duties center on the administrative tasks related to programs at employer facilities, which were not previously performed by the lab secretary.

In the previous decision dealing with the inclusion of the occupational medicine assistant position in the existing unit, I stated:

> The Employer's argument that the . . . petition raises a question concerning representation inappropriate for resolution through a unit clarification petition would perhaps be more pertinent if the petition had sought the inclusion of the recently created occupational medicine coordinator position. In those circumstances, if the recently created occupational medicine coordinator position were found to be nonprofessional and nonsupervisory and a successor position to the historically excluded occupational medicine services coordinator position, it might very well be concluded that regardless of the reason for the historical exclusion of the occupational medicine services coordinator position, the successor position could only be included in the existing nonprofessional unit by means of an appropriate self-determination election. (footnote omitted)

While the prior case did not present the issue of the inclusion of the occupational medicine coordinator, the instant case raises the issue.

In this case, the record establishes that the occupational medicine coordinator position is the functional equivalent of the historically excluded occupational medicine services coordinator position. The record further establishes that the occupational medicine services coordinator and its successor position at issue have been excluded from the existing bargaining unit represented by the Petitioner since 2002, even though the parties thereafter entered into a collective bargaining agreement without including the predecessor position. Moreover, since the disputed classification has not undergone recent, substantial changes, such classification should continue to be excluded from the unit.[30] See Bethlehem Steel Corp, 329 NLRB 243 (1999).

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[30] The Health Care Rules do not require a different result. Had I determined that the coordinator's position was the successor to the former lab secretary position, the coordinator's position would have remained in the unit under Premcor, Inc., 333 NLRB 1365 (2001), which is a result consistent with the policy against proliferation of bargaining units set forth in the Health Care Rulemaking. Further, had I determined that the coordinator's position was not a successor to the lab secretary or occupational medicine services coordinator positions, but was an entirely new position, I would have considered whether accretion of the new position into the existing nonprofessional unit was appropriate, with due consideration given to the policy underlying the Health Care Rulemaking.

In this case, however, I have found that the disputed coordinator position is a successor to the occupational medicine services coordinator position, which was excluded from the bargaining unit. My exclusion of the disputed coordinator position merely continues the practice of the parties that has been in effect since 2002.

For the reasons stated above, I find that no valid issue has been raised concerning the unit placement of the occupational medicine coordinator that is appropriate for resolution in a unit clarification proceeding. Accordingly, I will dismiss the petition.

VII. FINDINGS AND CONCLUSIONS

Based upon the entire record in this matter and in accordance with the discussion above, I find and conclude as follows:

1. The hearing officer's rulings made at the hearing are free from prejudicial error and are affirmed.

2. The Employer is engaged in commerce within the meaning of the Act and is a health care institution within the meaning of Section 2(14) of the Act and it will effectuate the purposes of the Act to assert jurisdiction in this matter.

3. The Union-Petitioner is a labor organization within the meaning of Section 2(5) of the Act.

Accordingly, for the reasons set forth above, I will dismiss the petition.

VIII. ORDER

IT IS HEREBY ORDERED that the petition filed herein be, and it hereby is, dismissed.

IX. RIGHT TO REQUEST REVIEW

Under the provisions of Section 102.67 of the Board's Rules and Regulations, a request for review of this Decision may be filed with the National Labor Relations Board, addressed to the Executive Secretary, 1099 14th Street, N.W., Washington, D.C. 20570-0001.[31] This request

[31] A request for review may be filed electronically with the Board in Washington, D.C. The requirements and guidelines concerning such electronic filings may be found in the related attachment supplied with the Regional Office's initial correspondence and at the National Labor Relations Board's website, www.nlrb.gov, under "E-Gov."

must be received by the Board in Washington by 5 p.m., EST (EDT), on **September 22, 2006**.

The request may **not** be filed by facsimile.

Dated: September 8, 2006

Gerald Kobell, Regional director

NATIONAL LABOR RELATIONS BOARD
Region Six
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